23
~~24~~. Services by Certified Family and Pediatric Nurse Practitioners. Services performed by certified family and pediatric nurse practitioners are covered if the services are within the scope of practice for advanced nurse practitioners, as defined by state law; are consistent with rules and regulations promulgated by the Texas State Board of Nurse Examiners or other appropriate state licensing authority; and are covered services under the Texas Medical Assistance Program.

Certified family and pediatric nurse practitioners are defined as registered nurses who are recognized by the state licensing board as credentialed to practice as family or pediatric nurse practitioners as a result of graduation from an accredited program for the training of family or pediatric nurse practitioners; or who are certified as such practitioners by the American Nurses' Association, or the National Certification Board of Pediatric Nurse Practitioners and Nurses. For services to be payable to these practitioners, the practitioner must be enrolled in and approved for participation in the Texas Medical Assistance Program; must sign a written agreement with the single state agency or its designee; must comply with the terms of the provider agreement and all requirements of the Texas Medical Assistance Program, including regulations, rules, handbooks, standards, and guidelines published by the single state agency or its designee; and must bill for services covered by the Texas Medical Assistance Program in the manner and format prescribed by the single state agency or its designee.

Certified family and pediatric nurse practitioners who are employed or remunerated by a physician may bill the Texas Medical Assistance Program and be paid directly for their services. (For the physician to bill, the nurse practitioner must agree that charges for his or her services may be included in the other entity's billing.) Services may not be billed by both the nurse practitioner and the employing/contracting entity if that billing would result in duplicate payment for the same services. If the services are reimbursable by the program, payment may be made to the entity (if approved for participation in the Texas Medical Assistance Program) who employs or reimburses the nurse practitioner. The basis and amount of Medicaid reimbursement depends on the services actually provided, who provided the service, and the reimbursement methodology utilized by the Texas Medical Assistance Program as appropriate for the services and provider(s) involved.

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DATE REC'D	9-26-90
DATE APP'VD	2-25-91
DATE EFF	7-1-90
HCFA 179	90-31

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24.a. Transportation.

Payment will be made for ambulance service, provided the following conditions are met and, except as provided herein for recipients who are "severely disabled" as that term is defined herein, the services are provided in accordance with laws, regulations and guidelines governing ambulance service under Part B of Medicare.

A. To be covered, ambulance service must be medically necessary and reasonable. Medical necessity is established when the recipient's condition is such that use of any other method of transportation is contraindicated and, in the case of a recipient who is "severely disabled", no other suitable transportation is available. For a recipient who is not severely disabled, when some means of transportation other than ambulance could be utilized without endangering such recipient's health, no payment may be made for ambulance service.

B. Any recipient who is "severely disabled" as that term is defined in this paragraph will be transported to and from the provider of his choice who is generally available and used by other residents of the community for any appropriate medical care included under the state agency's Title XIX plan. The transport must be prior authorized by the state agency or it's designee.

If no participating provider of the appropriate care is available within the community, transportation will be to and from the nearest participating provider who can provide appropriate medical care included under the state agency's Title XIX plan.

For purposes of this paragraph the term "severely disabled" means any individual whose severe physical handicaps limit his mobility to the extent that he must be transported by litter and/or requires a life support system.

Any recipient who is not "severely disabled" will be transported to the nearest hospital or skilled nursing facility which would ordinarily be expected to have the appropriate facilities for the treatment of the injury or illness involved. Ambulance service from a hospital or skilled nursing facility to this type of recipient's home is covered when his home is within the locality of the hospital or skilled nursing facility or where such recipient's home is outside of the locality of such hospital or skilled nursing facility but such hospital or skilled nursing facility is the nearest one with appropriate facilities.

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DATE RECD 2-9-98	
DATE APVD 3-16-98	
DATE EFF 1-1-98	
TN 98-01	

SUPERSEDES: TN • 88-21

24

23.a. Transportation (Continued).

B. (Continued.) The term "locality" with respect to ambulance service for Recipients who are not "severely disabled" means the service area surrounding the hospital or skilled nursing facility from which individuals normally come or are expected to come for hospital or skilled nursing services. The term "appropriate facilities," with respect to ambulance service for Recipients who are not "severely disabled" means that the facility is generally equipped to provide the needed hospital or skilled nursing care for the illness or injury involved. It is the institution, its equipment, its personnel and its capability to provide the services necessary to support the required medical care that determine whether it has appropriate facilities.

C. The ambulance services must be provided by an ambulance service supplier and the ambulance must be equipped as an ambulance and operated by trained personnel under appropriate rules, licensing or regulations of the area in which the ambulance is operated.

In addition to limitations specified above, medical transportation is limited as follows:

- The use of medical transportation must be for health-related purposes.

- Reimbursement will not be made to Title XIX recipients.

- Payment for medical transportation to and/or from providers of covered Title XIX services on behalf of eligible recipients will be made only where transportation is not otherwise available through the individual recipient's family, friends or community resources who will provide the services free.

- Payment will be made only to approved medical transportation providers.

- Exceptions to the transportation provisions contained in this plan may be authorized by the Commissioner, Texas Department of Human Services, or his designee when, in his opinion, circumstances of medical necessity warrant such exceptions.

- In order to be a covered benefit for which reimbursement may be made, the transportation which is provided must be appropriate to each eligible recipient's particular combination of physical limitations, geographic location and available source of care.

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DATE RCD NOV 29 1988
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24
~~23~~.b. Services Of Christian Science Nurses.

Not provided.

STATE TX
DATE REC'D
DATE APP'D JAN 18 1989
DATE EFF
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24
~~23~~.c. Care and Services Provided in Christian Science Sanitoria.

Christian Science Sanatoria Services for which payment will be made are intermediate care facility services (as defined at 42 CFR 440.150) considered appropriate by the single state agency which are provided to eligible recipients in Christian Science Sanatoriums that are operated by, or listed and certified by the First Church of Christ Scientists, Boston, Massachusetts.

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23.d

4.a. Nursing Facility Services for Individuals Under 21 Years of Age.

Nursing facility services (other than services in an institution for tuberculosis or mental disease) provided in a Title XIX nursing facility approved by the single state agency to eligible individuals are limited by a requirement for a medical necessity determination. The treating physician prescribes the nursing facility setting and the state agency provides the medical necessity determination for which payment will be made.

The nursing facility benefit includes drugs that are reimbursed through the Vendor Drug Program. This encompasses all drugs contained in the resident's plan of care, subject to the drug rebate provision of Section 4401 of the Omnibus Budget Reconciliation Act of 1990.

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DATE REC'D 6-10-91
DATE APP'D 11-2-91
DATE EFF 9-1-91
HCFA ID: 91-13

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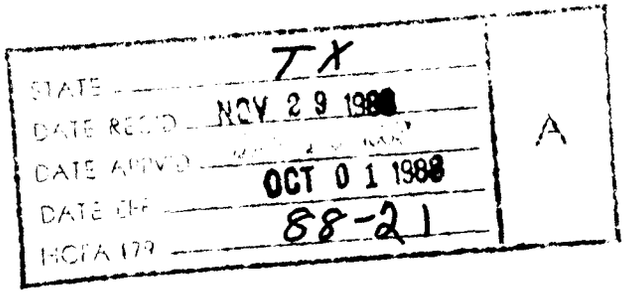
24
~~23~~.e. Emergency Hospital Services.

Payment for emergency hospital services is limited to hospitals approved for Title XIX participation by the single state agency.



24.f Personal Care Services

Subject to the specifications, conditions, and limitations established by the single state agency, payments will be made for Personal Care Services as defined at 42 CFR 440.170 (f) when provided to eligible recipients by providers who are approved by and under contract with the single state agency.

A. Prior approval to provide services is required in all cases.

B. Providers of Personal Care Services must meet qualifications established by the single state agency.

C. Services are limited to the lesser of:

- no more that fifty (50) hours per week per recipient, or

- the number of hours per week per recipient that may be provided within the limit of the cost of the average Medicaid nursing facility rate for recipients whose assessed medical needs can be met by long-term, non-technical medical observation and authorized assistance with the activities of daily living which are necessary because of a chronic medical condition complicated by functional limitations.*

D. As a condition for payment, Personal Care Services must be the primary need and may not be substituted for services needed to bring about improvement of an acute medical condition.

E. The range of Personal Care Services to be provided will be established by an assessment of the recipient's medical and functional needs. Reassessment of the functional need and authorization for continued Personal Care Services are required at least every twelve months.

F. A recipient's home is the recipient's full time abode but does not include a hospital, nursing facility, or any other setting in which nursing services or Personal Care Services are already available or could be made available by family members or sources outside the Personal Care Program.

*Durational, dollar, and quantity limits are waived for recipients of EPSDT services. Services allowable under Medicaid laws and regulations may be covered when medically necessary for these recipients.

SUPERSEDES: TN. 92-21

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DATE	9-30-97	
DATE	11-17-97	
DATE	8-1-97	
	97-13	

24
~~23~~.f. Personal Care Services (Continued).

G. A family member is defined as an individual with a duty under the Texas Family Code, Sections 4.02 and 12.04, to support the recipient, i.e., spouse for spouse and parent for minor child.

H. The provider must maintain records and submit reports and other information specified by the single state agency.

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DATE REC'D JAN - 9 1992
DATE APPV'D JAN 22 1992
DATE EFF JAN - 1 1992
HCFA 179 91-33

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24
~~23~~.g. Ambulatory Surgical Center Services.

Subject ~~to~~ the specifications, conditions and limitations established by the single state agency, ambulatory surgical center services are covered as follows:

A. Ambulatory surgical procedures provided in ambulatory surgical center facilities are limited to those approved by the Health Care Financing Administration for Medicare, unless otherwise specified by the single state agency.

B. Ambulatory surgical center services must be provided in an "Ambulatory Surgical Center" or "ASC" as defined by 42 CFR Part 416 and other applicable federal and state laws, rules and regulations.

C. Ambulatory surgical centers must meet applicable state laws, rules, regulations, and licensure requirements.

D. Ambulatory surgical center facilities or entities must be approved for and participating in Medicare (Title XVIII of the Social Security Act) and be approved by the single state agency or its designated agent and have a written provider agreement with the single state agency.

E. Ambulatory surgical center facility services are limited to those services furnished in connection with or directly related to a covered surgical procedure approved by the Health Care Financing Administration for Medicare unless otherwise specified by the single state agency.

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JAN 18 1989
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